



NURSE DELEGATION: NURSING ASSISTANT CREDENTIALS AND TRAINING

RESIDENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH (MM/DD/YYYY)	CLIENT ID NUMBER
NURSING ASSISTANT'S NAME		
<div><input type="checkbox"/> The RN Delegator has viewed certificates documenting this individual's credentials:<div style="margin-left: 20px;"><input type="checkbox"/> NA-R or NA-C <input type="checkbox"/> WA State Certificate/Registration Number _____ <input type="checkbox"/> Renewal Date _____ <input type="checkbox"/> Basic Caregiver's Course (Date) _____ <input type="checkbox"/> ND for Nursing Assistants (Date) _____</div></div> <div style="margin-top: 10px;">The RN Delegator has verified that the nursing assistant's registration or certificate is in good standing without restriction (Date) _____</div>		
RN DELEGATOR SIGNATURE		DATE
<div>Delegated Task(s): (Check One or More Below)</div> <div style="display: flex; flex-wrap: wrap;"><div style="width: 50%;"><input type="checkbox"/> MEDICATION ADMINISTRATION:<div style="margin-left: 20px;"><input type="checkbox"/> ORAL <input type="checkbox"/> GASTROSTOMY TUBE <input type="checkbox"/> TOPICAL (SKIN/NOSE/EAR/EYE) <input type="checkbox"/> VAGINAL SUPPOSITORY</div></div><div style="width: 50%;"><input type="checkbox"/> RECTAL SUPPOSITORY <input type="checkbox"/> ENEMA <input type="checkbox"/> INHALATION <input type="checkbox"/> OTHER: _____</div></div> <div style="margin-top: 10px;"><div style="display: flex; flex-wrap: wrap;"><div style="width: 50%;"><input type="checkbox"/> OSTOMY CARE <input type="checkbox"/> URINARY CATHETERIZATION (CLEAN TECHNIQUE) <input type="checkbox"/> GASTROSTOMY FEEDING <input type="checkbox"/> OTHER: _____</div><div style="width: 50%;"><input type="checkbox"/> DRESSING CHANGE (CLEAN TECHNIQUE) <input type="checkbox"/> NEBULIZER/OXYGEN <input type="checkbox"/> BLOOD GLUCOSE MONITORING <input type="checkbox"/> OTHER: _____</div></div></div> <div style="margin-top: 10px;">My signature below verifies that I have been informed, taught and instructed to perform the delegated task(s) and I accept responsibility for performing them as delegated. I have been given information on how to contact the RND if I am no longer able or willing to do these tasks, or the resident's health care orders change.</div>		
NURSING ASSISTANT SIGNATURE:		DATE

NURSING ASSISTANT'S NAME		
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